EXHIBIT M

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

CERTIFIED COPY

COYNESS L. ENNIX, JR., M.D., Plaintiff, vs. ALTA BATES SUMMIT MEDICAL CENTER, Defendant.	Case No.: C 07-2486 WHA (JCS)

*** CONFIDENTIAL ***
DEPOSITION OF WILLIAM ISENBERG, M.D., Ph.D.
VOLUME I

DATE: Thursday, November 29, 2007

TIME: 9:48 o'clock a.m.

LOCATION: MOSCONE, EMBLIDGE & QUADRA, LLP
220 Montgomery Street, Suite 2100
San Francisco, California

REPORTED BY: THERESA WARD, C.S.R. 9587

committee of the OB/GYN department.

Q And for what timeframe would you say you served in that role?

A I currently serve on that committee.

Q When did you start?

A I started in 2000.

Q Before 2000, did you have any role in the peer review process at Summit?

A Could you define "role" for me?

Q Well, okay. How does -- in general, how does the peer review process at Summit work, from the lowest level to the highest level?

A That is a very complicated and compound question.

Q Okay. How can I clarify that for you?

A All physicians who are members of the medical staff are under constant review of their activities. There are certain kick-outs, indexed outcomes, that are set or are recommended by the individual departments and are approved by the medical executive committee that will be used as indicators to initiate peer review processing.

Q Okay. So when when you say, "initiate a peer review process," what is the process that gets initiated?

MS. McCLAIN: Objection. Compound. It assumes only one process.

THE WITNESS: When an unexpected outcome occurs,

related to the individual under review?

A Well, bullet point number two of item two says peers may also include other medical staff members in good standing, not practicing in the same specialty as the individual whose case is under review.

Q Well, that is peers. Do you understand that to be the same thing as a peer reviewer in the prior bullet point?

A Yes.

Q Oh, okay. So that is synonymous, peer reviewer and peer?

A Yes. I think that that person identified in bullet point two has been asked to give his or her evaluation of the case as a peer physician member of the medical staff.

Q Well, it says they may be consulted regarding specific issues. The peer reviewer comes to a conclusion, correct?

A The peer review body comes to a conclusion.

Q Well, doesn't the peer reviewer?

A Each individual person may come to his or her own conclusion.

Q Well, okay. Let me step back. I thought that you said that a nurse could look at an unexpected outcome and say, I'd like a doctor to look at this.

A I did say that.

Q And that doctor who would look at that would be somebody with similar or related training and experience to the individual who performed the procedure, correct?

A That is correct.

Q And that doctor would reach a conclusion about whether or not it was within the standard of care, correct?

A I think I said that doctor could reach a conclusion that it was.

Q Okay. You wouldn't go to -- a nurse wouldn't go to a podiatrist to determine whether the outcome of a cardiothoracic surgery was within the standard of care, would a nurse?

A No.

Q You would only go to somebody who was in the same specialty, and in this case, cardiothoracic surgery, right?

A Correct.

Q If you go to the next page, there is a bullet point toward the bottom. We are on page D 0852. The bullet point towards the bottom says, "Circumstances requiring external peer review." You see that?

A Yes.

Q So then it lists some circumstances, the first of which is "Need for specialty review. When there are no medical staff members with the identified specialty within

A There are four elected officers of the medical executive committee, the chief of staff, the vice chief of staff, the immediate past chief of staff, and the secretary treasurer.

Q When did the officers ask the cardiothoracic peer review committee to consider changing its procedure, approximately?

A We suggested it to them right around the time of the first minimally invasive surgery cases. There were refusals on the part of some of the members to be involved at all in the peer review process regarding Dr. Ennix's cases specifically. So it became a difficult issue.

Q We are talking about two different things. You said that you had problems with the peer review process of the cardiothoracic surgery committee, including the fact that they allowed the physician being reviewed to attend meetings, even during deliberations over that physician, correct?

A Correct.

Q And did the officers recommend that the committee change those procedures?

A We recommended that they potentially decrease the number of members on the committee, and we recommended if they wanted to include the committee as a whole as they were doing that, when the person under discussion was being

discussed, they would leave the room.

Q Approximately when were those recommendations made?

A April of 2004.

Q Before that time, were you aware of what you considered to be problems or inadequacies in the peer review process of the cardiothoracic peer review committee?

A I personally was not aware of any.

Q Were you aware of -- let me tell you what I'm trying to get at. Are these issues that the officers dealt with only after the issues about minimally invasive cases came to light, or were these issues being addressed by anyone before April 2004? Can you enlighten me on that?

A To my knowledge, this was never a subject for discussion in any of my roles as an officer or member of the medical executive committee, the peer review process within that division. It became a subject of discussion with the advent of the minimally invasive questions in January, early February of 2004.

Q So at that time, in that timeframe, how was -- how did the officers communicate their recommendations to the cardiothoracic peer review committee?

A I don't have an existing document to refer to, but my recollection, and this is going back to early 2004, so almost four years, was that Dr. Steven Stanten and I,

after the officers and I had discussed it, met with Dr. Russell Stanten and communicated that we thought that the model employed by the department of surgery, which is a smaller number, not everybody in the department, and that if the individual member under discussion was on the committee, she or he would leave the room. We suggested that that model be used by CT surgery.

Q And what was Dr. Russell Stanten's reaction?

A My recollection of it was, "We have this method so that we can all learn from what happens, but I will take it back to the committee and we'll discuss it."

Q And was there subsequent dialogue?

A Not that I can recall.

Q Did you ever follow up to see if, in fact, they had changed their procedures?

A I did not.

Q But it is your understanding that they did not?

A It is my understanding that they did not.

Q And what is that based on?

A The concerns registered to me by members of the medical staff who are on that committee, that they felt inhibited about discussing peer review issues regarding Dr. Ennix subsequent to that date because he was in the room and refused to leave while those cases were being discussed.

Q Oh, okay. Not the -- we are not talking about the cases that formed the basis -- the corrective actions taken against Dr. Ennix?

A No, subsequent cases.

Q Got it. Okay. Given the concern that you had about issues being swept under the rug at the cardiothoracic peer review committee, did you look into unexpected outcomes of physicians other than Dr. Ennix that had been reviewed by that committee?

MS. McCLAIN: Objection to the term "swept under the rug." I'm not sure that is an accurate phraseology. Objection. Vague.

THE WITNESS: There were no other situations that had been brought to my attention by either the chair of surgery or the chair of anesthesia or both about the performance of cardiothoracic surgery by any other member of that division that prompted me to look more thoroughly at his or her outcomes.

BY MR. EMBLIDGE:

Q Right. But you had a concern about this process, correct, at the cardiothoracic peer review committee?

A I did.

Q Did you initiate any review of any of the other physicians' cases?

A I did not.

Q The outside peer reviewers or reviewer for the surgical oncologist, what -- who or what entity was retained to review the surgical oncologist?

A I was not party to that, so I don't know.

Q What about the geropsychiatrist?

A The Mercer Group, NMA was retained, National Medical Audit.

Q And so are you aware of any outside peer reviewer or peer review body engaged by Summit other than NMA?

A I personally am not.

Q Why do you qualify that as personally? Do you have any information that they have engaged someone else?

A No, I don't.

Q Were you involved in the decision to use NMA for Dr. Ennix's review?

A I was.

Q Who else was involved in that decision?

A There was a discussion with Counsel, Mr. Shulman, the director of the medical staff office, and Joanne Jellin, and I consulted with my predecessor, the immediate past president, which was Dr. Annette Shaieb, S-H-A-I-E-B.

Q You mentioned that you consulted with an office?

A The director of an office.

Q And is that --

A Joanne Jellin.

Q Thank you. Okay. I want to separate for a second two different decisions, the decision to engage outside peer review on the one hand, and the decision to engage NMA to perform the peer review on the other hand. Okay? As to the first decision, who was involved in that decision, the decision to have outside peer review?

A That was the ad hoc committee's decision.

Q And was anyone involved in that decision besides you, Dr. Paxton, Dr. Ly, L-Y, and Dr. Horn?

A Joanne Jellin was present at the meetings. I don't think she made any subsequent contribution to the discussion.

Q So other than the four of you, no one else was involved in the decision to engage outside peer review; is that correct?

A No. No.

Q The way you have answered the question, it is no, I'm not correct. So let me ask the question a different way.

A (Witness nodded in the affirmative.)

Q Was anyone involved in the decision to seek outside peer review of Dr. Ennix other than you, Dr. Paxton, Dr. Ly, and Dr. Horn?

A No.

Q Was -- how did you come to the decision to retain

NMA to review Dr. Ennix?

A As I mentioned, I had been involved in the initial decision to employ them in the geropsychiatric case and had been involved in the work product that they had generated. We, as officers and ultimately as an MEC, were quite satisfied with the thoroughness, the promptness, the completeness of their evaluation, and so when we decided at the level of the ad hoc committee to move to outside review, they were the first to come to mind.

I then discussed that with Mr. Shulman to see that he agreed with the propriety of that, and I asked Dr. Shaieb her opinion on whether she, too, had been equally satisfied with the outcome before we moved ahead.

I then -- something that I had not been involved in doing since I didn't make the initial engagement contact with NMA for the geropsychiatrist, was I went to their Website. I looked at their written materials. I saw who their principals were and what those principals' histories had been within the context of provision of quality care in this country, and I felt that they were a reasonable body to engage.

Q Who was involved in the decision to use NMA for the geropsychiatrist?

A The officers ultimately made the decision. Dr. Shaieb was the chief of staff and made the final -- I

am only presuming, because I know what happened with Mr. Shulman and I in Dr. Ennix's case. So I'm presuming that she made that final decision with counsels.

Q What role did you have in selecting NMA for the geropsychiatrist?

A We talked about getting an outside reviewer because of this person being the only member in this specialty. We queried counsel about experiences in this arena with outside review organizations and --

MS. McCLAIN: Dr. Isenberg, let me caution you not to disclose what counsel said. You can talk about the general discussion area.

THE WITNESS: And discussed with him this process and made use of his experience in this arena.

BY MR. EMBLIDGE:

Q Okay. But did you recommend NMA? Were you aware of NMA? What role did you have in selecting NMA for the geropsychiatrist?

A I was only involved in the discussions about getting an outside reviewer, and the next thing I knew, NMA had been engaged.

Q Were you aware of NMA before that?

A I was not.

Q Do you remember how or who brought up NMA in the first place?

January 4, 2005, letter to Dr. Smithline from Doctors Paxton and Isenberg.

(Plaintiff's Exhibit 1001 marked for identification.)

BY MR. EMBLIDGE:

Q Looking at Exhibit 1001, Dr. Isenberg, can you tell me who participated in the drafting of that letter?

A Dr. Paxton, myself, and Mr. Shulman saw a draft of it. I'm not sure that he was involved in much of the crafting of it.

Q Was anyone else involved in drafting this letter?

A Well, it was typed by the medical staff office, but as far as content goes, I think that is the extent of it.

Q How did you decide what information to put in this letter? That is a lousy question.

How did you decide what to refer -- how did you decide which cases to refer to NMA for review?

A The ad hoc committee first began looking at the minimally invasive cases, and so the first four cases that were submitted to NMA were those minimally invasive cases.

Q And as to the other six, how did you decide? Why six? Why these six? How did you make those decisions?

A The additional six cases came to light during the course of the ad hoc committee's meetings. Some were

A I think Dr. Smithline.

Q And am I correct that you, and as far as you know, Summit never had any direct communication with the reviewers, Doctors Breyer or Houseman? Am I correct about that?

A Yes.

Q On the previous case where Summit used NMA about the geropsychiatrist, did the NMA -- what did the NMA conclude about the geropsychiatrist and his performance?

A That it was outside the standard of care.

Q When you talked to Dr. Smithline or anyone else at the NMA, did you ever talk to them about how often they conclude, in their reviews, that someone is outside the standard of care?

A I did not.

Q Are you aware of any time that the NMA has done a review of someone and not concluded that the doctor was outside the standard of care?

MS. McCLAIN: Objection. Lack of foundation.

THE WITNESS: I have no knowledge.

BY MR. EMBLIDGE:

Q We talked about Dr. Khan and credibility issues, and then Dr. Lee and credibility issues, and we talked about the difference between what he said to Dr. Stanten and what he said to the ad hoc committee about mitral and

STATE OF CALIFORNIA)
) ss.
COUNTY OF SANTA CLARA)

I, THERESA WARD, a Certified Shorthand Reporter in and for the State of California, hereby certify that the witness in the foregoing deposition,

WILLIAM ISENBERG, M.D., Ph.D.,

was by me duly sworn to tell the truth, the whole truth, and nothing but the truth in the within-entitled cause, and that the foregoing is a full, true, and correct transcript of the proceedings had at the taking of said deposition, reported to the best of my ability, and transcribed under my direction.

Date December 2, 2007 Theresa L Ward

Theresa Ward, C.S.R. 9587

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
---oOo---

COYNESS L. ENNIX, JR., M.D., as an individual and in his representative capacity under Business & Professions Code Section 17200 et seq.,

Plaintiff,

vs.

No. C 07-2486

RUSSELL D. STANTEN, M.D. LEIGH I.G. IVERSON, M.D., STEVEN A. STANTEN, M.D., WILLIAM M. ISENBERG, M.D., Ph.D., ALTA BATES SUMMIT MEDICAL CENTER and DOES 1 through 100,

Defendants.

_____/

CERTIFIED COPY

CONFIDENTIAL

DEPOSITION OF:

WILLIAM ISENBERG, M.D.

VOLUME II

Monday, January 21, 2008

CONFIDENTIAL

Reported by:
Gina V. Carbone
CSR NO. 8249

HANNAH KAUFMAN & ASSOCIATES
Certified Shorthand Reporters
472 Pacheco Street
San Francisco, CA 94116
(415) 664-4269

the NMA -- let me ask that question better.

Who decided to send those six cases, as opposed to other cases, to the NMA?

A. My recollection is that five of the cases were the five cases that resulted in death. Five cases that Dr. Ennix had done during the time in 2004. And one was a case that came up during the interview with Dr. Donovan, during which time he expressed concerns regarding the consenting process and the management.

Q. Okay. That's sort of my -- the next question I was going to ask, which is what was the criteria used for selection. But the question I asked is who selected?

A. The ad hoc committee.

Q. Were you a member of the ad hoc committee?

A. No.

Q. But you attended all their meetings, right?

A. I did.

Q. Why is that?

A. The president of the medical staff is an ad hoc member of every medical staff committee at the hospital, and has the prerogative of attending any or none of any meeting that she or he wishes to. I wanted to preserve the fairness of this process to everybody, patients, Dr. Ennix, the medical staff, and I felt that

A. Yeah. I'm hazy on that, but that is now ringing true. I had forgotten that.

Q. Why would you, or anyone else at Summit, review and comment on a draft report from the NMA?

A. I can't think of an answer to that.

Q. You wanted their own outside independent review, right?

A. Yes.

Q. So doesn't it seem contrary to that intent to have them send you a draft for you to review and comment on before they provided you what was supposed to be independent outside input?

A. Well, you've taken me into the realm of hypotheticals. I could hypothetically say they could say this might be at variance with your rules, but we don't quite know what your rules are. So if you could provide us with them, then we'll tell you whether we think this practitioner was within the bounds of your rules or not. And I could see that as a reasonable clarification.

Q. Okay. If the NMA sent you their draft report for you to review and comment on before they finalized it, wouldn't that be contrary to your intent of seeking an independent outside report from them?

MS. McCAIN: Objection. Calls for

speculation. Lack of foundation.

THE WITNESS: I don't know how to answer the question.

MR. EMBLIDGE: Q. Well, would it be consistent with your intent in retaining the NMA or inconsistent with your intent in retaining the NMA?

A. I think I wanted to see what their work product was.

Q. Of course. But you wanted it to be outside independent work product, right?

A. Right.

Q. Okay. So my question is, that's what you wanted. Is it consistent with your desire or inconsistent with your desire for them to give you a report that they first send to you in draft form for your review and comment?

A. I don't see why I couldn't see it, as long as I didn't make substantive changes to it.

Q. Okay. So if they sent it to you and you made substantive changes, that would be inconsistent; is that right?

MS. McCAIN: Objection. Calls for speculation. Lack of foundation.

THE WITNESS: I think that the document should be as close to what they created as possible.

MR. EMBLIDGE: Q. Right. So if they sent it to you for your review and you made substantive changes, that would be inconsistent with what you wanted in retaining the NMA, right?

A. Yes.

Q. Did Mr. Shulman, to your knowledge, have input into the text of the NMA's report? The wording of the NMA report?

A. I'm not aware that he did.

Q. Okay. Let's shift focus a little bit and talk about how issues about Dr. Ennix came to your attention.

The minimally invasive surgery issues; those came to your attention from Dr. Steven Stanten; is that correct?

A. Dr. Steven Stanten, Dr. John Donovan and Dr. Maire Daugharty.

Q. Chronologically, do you recall the order in which those individuals brought the issues to your attention?

A. No.

Q. Okay. Prior to the time that those individuals brought to your attention issues relating to the minimally invasive cases, did you have any concerns, whatsoever, about the performance of Dr. Ennix?

A. I had received, at the end of December,

a regular basis, isn't it?

A. In what I felt was a problem-riddled way.

Q. What would be wrong with them knowing about a review of a doctor's cases when that's what they spend their time doing every month?

A. I wanted this done in an expedited way so that we could have answers that we could act on.

Q. I know you wanted it done expedited, but I'm talking about the word "confidential." So confidential means confidential from the other members of the cardiothoracic peer review committee, or confidential?

A. From any member -- from any other member of the medical staff.

Q. And you talked to Dr. Moorstein about this, correct?

A. So it would appear from the memo, yes.

Q. Do you recall that?

A. Yes.

Q. And he had what you called a persuasive recommendation. And one of his recommendations was that you shouldn't give the impression that you were circumventing internal peer review process; what did you understand him to mean by that?

A. That we shouldn't directly send these cases to outside review.

Q. And who were you trying not to give the impression to that you were circumventing internal peer review processes?

A. Anybody.

Q. And why was that important, that you not give that impression to anybody?

A. Well, I don't think that the members of the medical staff would like it very much -- any member of the medical staff would like it very much if the immediate response of medical staff leadership was to send cases outside for review before the internal designated body had a chance to look at it. It's peer review.

Q. And here you weren't going to have the internal designated body look at them, were you?

A. I was having a subset of the internal body look at them.

Q. One person. That's the subset?

A. That's the subset.

Q. Are you aware of any other time where a case involving a cardiac surgeon was reviewed by a subset rather than by the cardiothoracic peer review committee?

A. I am not.

MR. EMBLIDGE: Let's mark as 1079, a document Bates stamped D4151.

A. I don't know the answer. Dishonesty implies motivation, and I don't know what his motivation was.

Q. Given your concerns about the cardiothoracic peer review process at Summit, what have you done to address those concerns systemically?

A. Well I had a talk with Russell Stanten, the chief of service, about the construction of the peer review committee itself, and the way that I thought it might be better served to be a multi-disciplinary team involving anesthesiologists, cardiac surgeons and calling in cardiologists on an ad hoc basis as necessary.

I suggested that it not be a committee of the whole. That it, instead, be with representatives. I suggested that the person under review be allowed to participate in the process. That is, give their perspective on the case, but when the final deliberations went on, that person should leave the room.

Q. And the multi-disciplinary aspect you are suggesting that the cardiothoracic peer review committee be composed of cardiothoracic surgeons plus members who are not cardiothoracic surgeons; is that correct?

A. Yes.

Q. Are you aware of any institution that does

peer review that way?

A. I'm aware of a lot of institutions that are using cross-disciplinary approaches more and more for patient management. And I think that since it's -- there is nothing that exempts a member of another department from participating in the peer review process, it would probably be advantageous to include them.

Q. You haven't done that in OB-GYN, have you?

A. Well, we didn't at the -- we did at the Summit campus, and I believe it is done at the Ashby campus. Right now there is a neonatologist that sits on the OB peer review committee.

Q. As a member?

A. As a member.

Q. And are you aware of any institution, not that looks across disciplinary issues for patient care, but that has a multi-disciplinary peer review committee, like you were suggesting to Russell Stanten, at a department level?

A. I am not aware of any that actively do that.

Q. So you made these suggestions to Russell Stanten approximately when? You can give me a year. Just whatever your best estimate is.

A. Yeah. I think probably mid to late 2004, or

early 2005.

Q. And what is your understanding about what, if anything, he's done to act on those recommendations?

A. Well, it is my understanding that there are attempts being made right now to limit the number of members on the peer review committee. This lawsuit has cast a pall over that process, however. I don't know what he has done with the suggestion that I made about other members. I am no longer chief of staff, so I regularly don't meet with Russell Stanten about these issues.

Q. Okay. This lawsuit was filed in April of 2007. Between the time you talked to Russell Stanten and the time this lawsuit was filed, what, if anything, are you aware of that the cardiothoracic surgery division did to address your concerns about its peer review process?

A. I am unaware that they did anything.

Q. Doesn't that give you concern about patient care if you think that the peer review process that an important division like cardiothoracic surgery is engaging in might not result in thorough objective peer review?

A. Yes. It is concerning.

Q. So why not do something about it?

So in contrast to a fairly recent interview with Mr. Lovin, I wanted to let the ad hoc committee know that I had heard this. She had written this letter.

Q. Did you call their attention to any letters that came in from cardiac surgeons?

A. I'm trying to remember. The only cardiac surgeon that I really recall we got a letter from was Dr. Khan, and the committee interviewed him. So I -- I'm not remembering any other.

Q. What about Dr. Durzinsky?

A. Maybe he did write one.

Q. Did you call that to their attention?

A. I can't, off the top of my head, remember.

Q. Did you call to their attention any letters you received from cardiologists?

A. I can't recall, off the top of my head.

Q. On May 11th, 2005 you decided to summarily suspend Dr. Ennix, correct?

A. That's correct.

Q. What was the basis for your decision?

A. Falsification of a medical record.

Q. Anything else?

A. We had recently received the NMA report that had elements of criticism in it regarding his

performance, his clinical performance and judgment.

Q. I know, did that -- did you suspend him, in part, because of the NMA report?

A. Well, it just so happened that that was received right at the time, and so it was part of the discussion.

Q. I understand. I understand the confluence of time. I want to know in your decision that you made to suspend Dr. Ennix, was it solely because of the falsification of the medical report, or did you decide to suspend him in part based on the NMA report?

A. I believe there were elements of the NMA report that factored into the decision to suspend him. Yes.

Q. What elements?

A. Well, there were elements about judgment, decision making and documentation that were recurring themes in the NMA report, and had been made patently clear to Dr. Ennix on numerous occasions at the initiation, and through the process of this report -- through the process of this investigation. And so for a practitioner who was aware that his practice was being looked at, and who knew that documentation issues had already been considered significantly poorly done, for him to falsify the medical record, misrepresent to the

officers about that whole process, to me seemed quite worrisome.

Q. Okay. But what was it in the NMA report that caused you to summarily suspend Dr. Ennix?

MS. McCAIN: Objection. Asked and answered.

MR. EMBLIDGE: Q. Go ahead.

A. I thought that I had just said that the elements regarding technical performance, judgment, and documentation which were recurring themes in the NMA report were then reinforced by this huge documentation problem and falsification of the medical record.

Q. At this point, the NMA report, had anyone at the hospital seen it besides you?

A. I'm not sure.

Q. And it was a report that was meant to assist the ad hoc committee, right?

A. It was.

Q. And the ad hoc committee hadn't reviewed it, had they?

A. No.

Q. And Dr. Ennix hadn't seen it or had an opportunity to respond to it, had he?

A. He had not.

Q. But you felt it was appropriate to summarily suspend him in part based on that report?

A. Yes.

Q. Why?

A. Because I think there were elements of concern expressed in that report that were reinforced by the behavior that I had witnessed in what he had done regarding this case.

Q. Even though you, an OB-GYN, were the only person who had reviewed the report?

A. It doesn't take a cardiothoracic surgeon to recognize fraud.

Q. Well, the report did not accuse him of fraud, did it?

A. No. But that's what his suspension largely revolved around was his fraud.

Q. I'm not asking about your allegation of fraud, I'm asking about you basing your decision in part on the conclusions in the NMA report.

Now fraud, what do you mean by that?

A. I mean that Dr. Ennix represented in the medical record that he had done something, had written a note on a day that he had not written it. He had falsely represented that he had done something.

Q. Right. Okay. So do you believe Dr. Ennix did not see the patient on the date reflected in the note that you are claiming was false?

STATE OF CALIFORNIA

I do hereby certify that the witness in the foregoing deposition was by me duly sworn to testify the truth, the whole truth, and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place therein stated; that the testimony of the said witness was reported by me, a Certified Shorthand Reporter and a disinterested person, and was under my supervision thereafter transcribed into typewriting; that thereafter, the witness was given an opportunity to read and correct the deposition transcript, and to subscribe the same; that if unsigned by the witness, the signature has been waived in accordance with stipulation between counsel for the respective parties.

And I further certify that I am not of counsel or attorney for either or any of the parties to said deposition, nor in any way interested in the outcome of the cause named in said caption.

IN WITNESS WHEREOF, I have hereunto set my hand the 1st day of February, 2008.

Linda V. Cantoni

Certified Shorthand Reporter

CSR No. 8249